BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: BELEN S., Claimant, vs. SOUTH CENTRAL LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. L 2006110591

DECISION

This matter was heard by Deborah Myers, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), in Los Angeles, California, on February 26, 2007.

Judith Enright, Attorney at Law, represented South Central Los Angeles Regional Center (Service Agency).

Belen S. (Claimant), who was not present, was represented by Ana S., her mother, who was assisted by a Spanish interpreter.

Claimant seeks a determination that she is eligible for services under the Lanterman Developmental Disabilities Services Act (the Act) based on a diagnosis of mental retardation or, in the alternative, on the basis of having a disabling condition closely related to mental retardation or requiring treatment similar to that needed by people with mental retardation (commonly referred to as the "fifth category"). The Service Agency contends that testing of Claimant's cognitive abilities has shown that Claimant does not have mental retardation or any other qualifying condition, and therefore, Claimant is not eligible for services.

The parties presented oral and documentary evidence. The parties stipulated to close the record on April 19, 2007 to allow for a more thorough record review.

ISSUE

The parties agreed that the issue to be decided was:

Does Claimant have a developmental disability that makes her eligible for services provided by the Service Agency under Welfare and Institutions Code[1] section 4500 et seq., under either the category of mental retardation or "fifth category?"

FACTUAL FINDINGS

1. Claimant is a nine-year old girl who lives with her mother. The Service Agency denied Claimant's request for eligibility on November 16, 2006. Claimant requested a fair hearing to appeal the Service Agency's determination, and this matter ensued.

2. On a date prior to March 4, 2005, the Los Angeles United School District (District) conducted an evaluation and determined Claimant was eligible for special education services. Under the Individuals with Disabilities Education Act, the District is required to test for all areas of suspected disabilities. However, case law does not allow it to use Intelligence Quotient (IQ) tests. Instead, the District conducted other tests, such as the Test of Auditory–Perceptual District (TAPS) and the Alternative Assessment test. The District found Claimant eligible under the category of specific learning disability. Her initial Individualized Education Plan (IEP) of March 4, 2005, partially summarized Claimant's test results. Claimant tested in the low average range in auditory processing and in the average range of cognitive ability. The IEP team determined that, although Claimant was in second grade, she functioned academically at the kindergarten level, and, therefore qualified for placement in special day classes with inclusion in general education classes. (Exhibit B.)

3. The District noted Claimant's high average scores in visual figure-ground and visual memory. Claimant had average abilities in visual discrimination, visual spatial-relationships, pattern completion, reasoning by analogy, and serial reasoning. She had low average abilities in visual form-constancy, aural/oral, and visual/written subtests, placing her in the borderline range. She demonstrated a process disorder in auditory processing in her primary language. District personnel concluded that Claimant had a specific learning disability with deficits in auditory processing. They did not conclude she had mental retardation. (Exhibit B and Testimony of Dr. Collister.)

4. Claimant received a second IEP on October 3, 2005, at her mother's request. The IEP team reviewed and discussed Claimant's academic progress in third grade, but did not increase or decrease her special education services. She continued to require a special day program of 1,550 minutes per week, and she remained eligible based on her severe learning disability. Claimant's math skills were at a first grade level, and her reading skills were below first grade level. (Exhibit C.)

[1] All further references are to the Welfare and Institutions Code, unless specified otherwise.

5. On January 25, 2006, when Claimant was eight years, three months old, Ann Walker, PhD., conducted a psychological evaluation of Claimant. Dr. Walker was unable to accurately measure Claimant's cognitive, intellectual and academic skills due to the auditory and visual hallucinations Claimant experienced throughout the evaluation, which prevented Claimant from concentrating on the testing material. Dr. Walker noted that she had to repeat instructions to Claimant several times, in both English and Spanish. Dr. Walker reviewed Claimant's initial IEP of March 4, 2005, which she believed showed Claimant's cognitive intellectual abilities were in the normal range and concluded that it was likely her true cognitive intellectual functioning fell within the average range. Dr. Walker believed Claimant exhibited a learning disorder with a weakness in auditory processing. She also believed that Claimant exhibited a thought disorder with frequent tangibility and derailment, depression, and Schizoaffective Disorder based upon Claimant's description of almost constant hallucinations. (Exhibit F.)

6. Dr. Walker administered the Leiter-R to test Claimant's cognitive skills, which were found to be in the moderate range of mental retardation with a scaled IQ score of 38. Dr. Walker believed this score significantly underestimated Claimant's true abilities due the distraction resulting from Claimant's auditory hallucinations during the examination. Claimant's Wide Range Achievement Test-Revision 3 (WRAT-3) scores placed her at the kindergarten level for reading recognition, spelling, and arithmetic skills. Claimant's scores on the Beery Developmental Test of Visual Motor Integrated Skills, placed her at an age equivalent of five years, six months. Claimant's adaptive behavior composite scores on the Vineland Adaptive Behavior Scales were 62, and her communication and daily living subtest scores placed her in the mild range of mental retardation. Her daily living skills subtest score was 55 due to her inability to dress without assistance, to maintain proper hygiene without help, and to pick up after herself. (Exhibit F.)

7. Dr. Walker emphasized that she did not believe her evaluation accurately measured Claimant's cognitive intellectual or academic skills due to the constant hallucinations that Claimant reported to Dr. Walker during the evaluation. Dr. Walker believed the hallucinations "made it impossible for Belen to concentrate and give the evaluation the focus and attention needed to provide accurate results." She noted that the March 4, 2005 IEP determined that Claimant's intellectual abilities were within the normal range in a psycho-educational evaluation, although she did not personally review that evaluation. The record did not contain that evaluation, and the record did not establish who performed that testing. Dr. Dr. Walker's diagnosis was as follows:

Axis I:	295.70	Schizoaffective Disorder, Depressive Type.
Axis II:	V71.09	No Diagnosis
Axis III:	V71.09	No diagnosis
Axis IV:	2	
Axis V:	50	

8. The Service Agency's current determination that Claimant does not have a developmental disability is based largely on the September 8, 2006 report by Timothy D. Collister, Ph.D., who performed a psychological evaluation of Claimant, and who testified at the administrative hearing. Dr. Collister earned his Doctorate in Clinical Psychology in 1989 from Fuller Theological Seminary, interned at Los Angeles County/University of Southern California School of Medicine, and completed his teaching fellowship at Boston University School of Medicine. In 1991, he became a licensed psychologist in California. Dr. Collister serves on the Department of Mental Health panel for "best testing standards and practices," and serves on the Evidence Code section 730 panel as an expert witness for the Los Angeles Superior Court Dependency and Competency divisions.

9. Claimant's mother provided Dr. Collister with Claimant's pertinent history as follows: Claimant began receiving special education services in third grade (last year). She began psychotherapy at Kedren Mental Health (Kedren) in June 2004, for Bipolar Disorder NOS.[2] She began "hearing voices" at age five. Claimant is under the care of a psychiatrist, and her auditory hallucinations have improved with the help of medication. Claimant's mother reported that Claimant had not experienced such hallucinations for some time, as "they're giving her medicine that helps," referring to Trileptal, which replaced a previous, less effective drug. Dr. Collister also reviewed Claimant's mental health records from Kedren which described her as exhibiting severe, pervasive behavioral, emotional and academic problems. Angel Rendon, M.D. of Kedren diagnosed Claimant with bipolar disorder and referred her to the service agency twice to rule out mild mental retardation and to determine if she were eligible for services. Dr. Collister also reviewed Dr. Walker's psychological evaluation of January 25, 2006. (Exhibits A-5, D and J and Testimony of Dr. Collister.)

10. Dr. Collister administered the Weschler Intelligence Scale for Children-Fourth Edition (WISC-IV), which resulted in a full scale IQ score of 67, within the mild mental retardation range, which is 50 to 69.[3] However, her verbal comprehension score of 75, her perceptual reasoning score of 75, and her processing speed score of 78, all areas not affected by memory, were above that range. Claimant's working memory score was 59, a score in the mild retardation range. Claimant achieved higher scaled scores in the Symbol Search (9)(average range), the Picture Concepts (7)(low average range), the Matrix Reasoning (7)(low average range), and the Comprehension (8)(low average range) subtests. However, Claimant was "deficient" in the two memory subtests, the Digit Span (2) and the Coding (3). These scaled scores demonstrate the dramatic spread of Claimant's scores and her areas of strength in verbal intellectual processing and nonverbal intellectual processing and her weakness in working memory. Dr. Collister opined that if her working memory score was consistent with her other scaled scores, that her IQ would be higher. He believed those deficits in memory were most likely caused by Claimant's active psychiatric disorders of Bipolar Disorder and the possibility of Attention Deficit/Hyperactivity Disorder (ADHD),

[2] Not otherwise specified.

[3] The standard error of measurement places the confidence range at 65-75 to support a diagnosis of mild mental retardation.

as each of those diagnoses involves significant difficulties in attention, concentration and memory. He believed if Claimant were to be treated with medication for ADHD, that her working memory would likely improve and as a result, her IQ scores would likely improve. (Exhibit A-5 and Testimony of Dr. Collister.)

11. Claimant's scores on the WRAT-3 were at the kindergarten level for Reading (scaled score of 60) and Arithmetic (scaled score of 47), and at the first grade level for Spelling (scaled score of 74). Her Vineland scores demonstrated an age equivalence of two years, seven months in Daily Living Skills (scaled score of below 20), three years, six months for Socialization (scale score of 56), three years, five months for Motor Skills (scaled score of 56), and five years, 11months for communication (scaled score of 64), with an overall composite of four years (scaled score of 43.) Dr. Collister also noted that Claimant's achievement was similarly affected by her difficulty with attention and memory. (Exhibit A-5 and Testimony of Dr. Collister.)

12. The Vineland Adaptive Behavior Scale determined Claimant was operating at a moderate range of delay, at a 4 year-old age equivalent when she was eight years, eleven months-old. Her communication domain, socialization, and motor skills fell in the mild range of delay. Her daily living skills fell in the profound range of delay. (Exhibit A-5 and Testimony of Dr. Collister.)

13. Dr. Collister's diagnostic impression was:

Axis I:	296.7	Bipolar Disorder, Not Otherwise Specified (per history, consistent with current findings).
	314.01	(Rule Out)[4] Attention Deficit/Hyperactivity Disorder (if not better explained by 296.7 above).
	315.9	Learning Disorders, Not Otherwise Specified.
Axis II:	V62.89	Borderline Intellectual Functioning.
Axis III		None.

(Exhibit A-5 and Testimony of Dr. Collister.)

14. Dr. Collister testified that the District's assessment of Claimant supports his conclusion. He explained that the District tested her for mental retardation by using the TAPS and the Alternative Assessment test. However, Dr. Collister did not explain how this assessment would test for IQ. The District also tested Claimant with the Kaufman Test of Educational Achievement (KTEA), a reading test, which demonstrated an age equivalent of seven years. The District determined her auditory processing deficits were affecting her ability to perform her language arts skills. Dr. Collister opined that if Claimant's non-verbal scores had been as weak as her verbal scores, then the District would have evaluated her

[4] "Rule Out" means that the diagnosis is not certain, and that further testing should be conducted to "rule out" the existence of that condition.

further for borderline intellectual function or mental retardation. However, this is speculation on his part as he does not have personal knowledge as to what the District would have done. Dr. Collister opined Claimant had significant non-verbal strengths, and therefore her results did not support a conclusion of mental retardation. Her areas of strength were "quite strong", and her areas of weakness were "quite weak." He concluded that her higher test scores supported a diagnosis of specific learning disability, not mental retardation. (Exhibits B, A-5 and Testimony of Dr. Collister.)

15. Dr. Collister opined that his observations and testing of Claimant did not support a conclusion that Claimant had mental retardation. He also opined that she did not meet any criteria of the "fifth category," although he admitted he did not test for it. Rather, he believed her current test results demonstrated borderline intellectual functioning except for aspects of function affected by either ADHD or bipolar disorder. Dr. Collister concluded that Claimant's difficulty with attention and memory on the WISC-IV was pronounced and statistically significant in relation to her much higher scores for verbal comprehension, perceptual reasoning and processing speed. He believed her overall cognitive function was limited by her working memory and concentration, which were related to ADHD and/or her bipolar disorder. Dr. Collister believed she is in the early process of treatment for her mental problems, which explains her rapid fluctuations during the past two years. While she does function at the level of a person with mental retardation during an active psychotic episode, those hallucinations have diminished due to her current medication. Claimant did not report any hallucinations during his assessment. Dr. Collister opined that Claimant experienced the onset of psychotic episodes beginning in 2004, and that she requires psychiatric treatment for ADHD and her bipolar disorder, but that she did not require treatment similar to an individual with mental retardation. (Exhibit A-5 and Testimony of Dr. Collister.) Dr. Collister did not satisfactorily explain why a person with significantly decreased intellectual function and significantly decreased adaptive behavior function did not have a condition similar to mental retardation.

16. Dr. Collister noted Claimant's previous testing showed low average to borderline intellectual functioning. He believed her achievement of both high and low scores, or scatter, were not characteristic of mental retardation. He believed her achievement of higher scores is not characteristic of mental retardation as well. Dr. Collister opined that Claimant's cognitive functions were fluctuating due to her recently developed psychiatric conditions,[5] and that her mental health needed to stabilize before a true assessment of her cognitive functions could be made. Because her condition appears to be based solely on psychiatric disorders or severe learning disabilities, he did not believe she was eligible for regional center services. (Exhibit A-5 and Testimony of Dr. Collister.)

17. Dr. Peter Adler, the service agency's Chief Psychologist, testified at the hearing having reached similar conclusions to those of Dr. Collister. He also opined that

[5] Claimant had scored in the average range for cognitive functioning one year before Dr. Walker's evaluation, when Claimant experienced active auditory and visual hallucinations during Dr. Walker's testing process.

Claimant's history of higher test scores in the recent past was not consistent with mental retardation or fifth category. Dr. Adler opined that Claimant's series of emotional problems, bipolar disorder and schizoaffective disorder affected how she responded to cognitive testing. Additionally, if Claimant had mental retardation or fifth category, Dr. Adler would have expected to see low scores in all areas of testing. Instead, in his opinion, Claimant obtained both high scores and low scores in the cognitive tests. Dr. Adler believed her recent mental health issues brought her scores down into the borderline range. He also believed that Claimant's scores would improve as her mental health issues improved.

18. On March 22, 2006, the District referred Claimant for an Assembly Bill 3632 mental health assessment through the Department of Mental Health (DMH). DMH provides services to children who have psychiatric difficulties which impair learning. Claimant was approved for services from DMH, with a diagnosis of:

AXIS I.	312.9	Disruptive Behavior Disorder
	296.80	Bipolar Disorder NOS
II	799.9	Deferred[6]
III		Overweight
IV		Psychosocial stressors: Educational, Social Environment
V		GAF-45

(Exhibits A-4)

19. The Kedren Acute Psychiatric Hospital and Community Mental Health Center has provided Claimant with various forms of daily therapy as part of their Children's Day Treatment Intensive Program for her Bipolar Disorder NOS. Claimant began receiving mental health services from Kedren on June 14, 2004, and had been treated by Dr. Angel Rendon, a Child and Adolescent Psychiatrist. While Dr. Rendon has only diagnosed Claimant with Bipolar Disorder NOS, a Kedren licensed clinical social worker diagnosed Claimant under AXIS I with ADHD, a Learning Disorder, and Bipolar Disorder NOS. The record did not contain any evidence of testing for ADHD. Claimant was prescribed Trileptal for her hallucinations by at least October 2005, and Abilify by at least February 24, 2006. By March 2006, her medication was changed to Depakote and Risperal. In the past, she had also been prescribed Seroquel and Geoden. However, neither the Department of Mental Health nor claimant's treating psychiatrist diagnosed her with ADHD. (Exhibits A-4, A-6, D, I and K.)

20. Claimant's mother described Claimant's behavior as "not normal." She described Claimant's angry outbursts and a lack of awareness of hurting other children. Claimant's mother also described Claimant's difficulty with self-care skills. Dr. Rendon had encouraged her to apply to the service agency twice to rule out mental retardation, due to the global delays he observed as her psychiatrist. (Testimony of Claimant's mother, Exhibits D and J.)

[6] No explanation was provided as to why this diagnosis was deferred.

LEGAL CONCLUSIONS

1. Claimant has the burden of proof as to each fact necessary to establish her eligibility for services provided by the Service Agency. (Evidence Code section 500.)

2. Section 4512, subdivision (a), states:

> (a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

3. Section 4512, subdivision (*l*), in relevant part states:

> (*l*) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity as determined by a regional center, and as appropriate to the age of the person:
>
> (1) Self-care.
> (2) Receptive and expressive language.
> (3) Learning.
> (4) Mobility.
> (5) Self-direction.
> (6) Capacity for independent living.
> (7) Economic self-sufficiency.

4. California Code of Regulations, title 17, section 54000 sets forth virtually identical criteria, but adds the following language:

> (c) Developmental Disability shall not include handicapping conditions that are:
> (1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. . . .
> (2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated

> cognitive potential and actual level of performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder or sensory loss. . . .

5. The Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision 2000) (DSM-IV-TR), describes mental retardation as follows:

> The essential feature of Mental Retardation is significantly sub average general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.
>
> *General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly sub average intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.
>
> Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical

> conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR, pages 39 - 42.)

6. Claimant asserts that she has mental retardation, or in the alternative, a condition closely related to mental retardation, or a condition which requires treatment similar to treatment required for individuals with mental retardation. Claimant has been evaluated by two psychologists and by the District. While the District was required to evaluate her for all areas of suspected disability, and only found a specific learning disability, it is noteworthy that it did not conduct an IQ test. Dr. Collister did not sufficiently explain how the alternative tests conducted by the District would have determined her IQ. Dr. Walker conducted an evaluation in January 2006, while Claimant was experiencing an active schizophrenic auditory and visual hallucination, and determined her evaluation results likely significantly underestimated her true cognitive intellectual abilities. Claimant's medication then changed from Abilify to a combination of Depakote and Risperal by March 2006. Dr. Collister conducted an evaluation in September 8, 2006, and his test results demonstrated a full scale IQ of 67, a score within the mild range of mental retardation. However, he opined Claimant's low tests scores were affected by her comprised working memory, which was likely affected by her bi-polar disorder or possibly by ADHD. Dr. Collister also believed that her higher cognitive scores in other areas were not characteristic of mental retardation. Dr. Collister opined the most likely explanation was that her psychotic disorders bipolar disorder and possibly ADHD affect memory, and that her IQ score was lower due to the interference of her mental health disorders.

7. Dr. Collister's opinion is speculative and not convincing. While he and a Kedren licensed clinical social worker considered a diagnosis of Rule-Out ADHD, and it is not otherwise supported by the record. Moreover, Claimant received a score of 38 on the Leiter during an active hallucination, and a 67 on the WISC without an hallucination while taking a different medication, which, from all evidence, successfully managed her hallucinations. Claimant's other test scores on the WISC were not statistically significantly higher, and still place her within the range for mild mental retardation. At the very least, her scores are sufficiently low that, together with Claimant's adaptive functioning deficits, they justify a finding that Claimant suffers from a condition similar to mental retardation.

8. Claimant's condition causes substantial impairment of Claimant's functioning in the areas of communication, socialization, motor skills, learning, and self-care. Her recent Vineland score of 43 places her at an age level of four years-old when she was eight years, ten months-old. Her daily living skills score placed her at an age level of two years and seven months-old. Her broad adaptive functions in the domains of communication, daily living skills, socialization, and motor skills are global and severe.

9. Although Claimant has established that she has significant functional limitations in these areas, almost all of the testing indicates that Claimant's disabling

condition, and consequent impairments in adaptive functioning, are most closely related to learning disabilities or psychiatric problems. Under California Code of Regulations, title 17, section 54000, these conditions are excluded from the definition of handicapping conditions only if they are the only diagnosed conditions. Claimant suffers from a developmental disability similar to mental retardation in addition to a psychiatric disorder and a learning disorder. This co-morbidity does not preclude her from qualifying for Regional Center supports and services.

10. Claimant has established she has an IQ score of 67, a score in the range of mild mental retardation, even taking into account the five-point standard error of measurement. At the very least, even if a lack of medication causes her IQ scores to be usually low, as Dr. Collister opined, she has a condition closely related to mental retardation.

11. Claimant is eligible for the services provided by the Service Agency.

ORDER

Claimant's appeal of the Service Agency's determination that she is not eligible for services is sustained. The Service Agency shall accept Claimant as a consumer forthwith.

Dated: April 28, 2007

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DEBORAH MYERS
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter and both parties are bound by this Decision. Either party may appeal this Decision to a court of competent jurisdiction within 90 days.